MEDICARE LEARNING NETWORK - COMPUTER/WEB-BASED TRAINING

FRONT OFFICE AND MEDICARE

Welcome to the Front Office and Medicare training course!

Hi. I'm Ms. Pearson and I work here at Main Street Medical Associates. I welcome and register new patients into our facility everyday. When I first started this job, I was told generally what my responsibilities were, but I didn't realize how important front office tasks are to Medicare claims processing. Now that I have been on the job for a while and have had the opportunity to talk with the people at our local Medicare contractor's office, I have a good understanding of why the patient registration process and front office tasks are vital for successful Medicare processing.

This course will teach you the important steps to take as a front office person gathering patient information, and why ensuring that information is accurate is so important to your office or organization.

Thanks for stopping by!

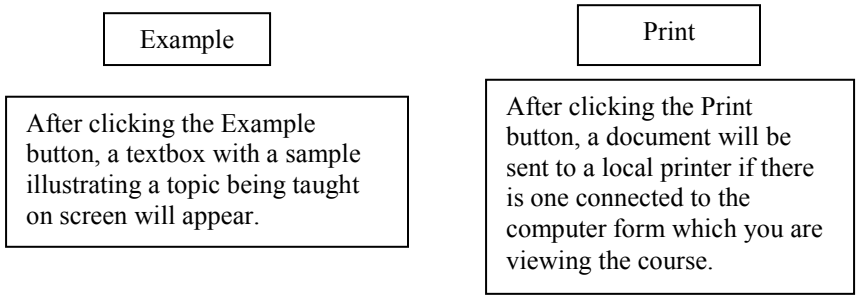
This course starts with a very brief Preliminary Knowledge Assessment so you can see what you already know about patient registration and front office tasks.

Next, you will continue to the lesson menu. The first lesson in the course provides an overview of basic Medicare concepts. More detailed information about Medicare can be obtained from the World of Medicare computer-based training course, or by calling your local Medicare contractor.

After that brief introduction, the remainder of the course focuses on what you need to know about patient registration and record keeping to help ensure proper Medicare claim filing.

The entire course should only take you about 40 minutes to complete.

In addition to screen text and images used to present information, you will see an Example button and a Print button.



There may also be other images throughout the course that you can click for more information. Be sure to read the prompt line for instructions.

Preliminary Knowledge Assessment

You must begin with the Preliminary Knowledge Assessment to determine how much you already know about how front office tasks are related to Medicare claim processing.

This brief Assessment asks you to answer a series of questions about Medicare-related front office tasks. After you have answered all of the questions, Assessment feedback is given to help you understand your level of knowledge of the course subject matter.

You can enter the course once the entire Preliminary Knowledge Assessment has been completed.

!IMPORTANT!

Make sure you select an answer on each screen before clicking the Right Arrow button to continue. You are not allowed to go back to screens in the Preliminary Knowledge Assessment and any screens without an answer selected will count as incorrect.

Match the term on the left with its correct description on the right.

	A federal health insurance program established by
Beneficiaries	Congress for the elderly, the disabled, and individuals afflicted with end-stage renal disease (ESRD).
Medicare	Those entitled to Medicare benefits under the Social Security Administration.
Medicare Part B	Supplementary Medical Insurance (SMI), that covers physician services, outpatient hospital services, diagnostic tests, clinical laboratory services, outpatient physical therapy, speech therapy services, etc.

Select the eligibility requirement(s) for becoming a Medicare Part B beneficiary.

- Over 65 and receiving Social Security
- Under 65 and fully employed
- Under 65 receiving payments from a private pension plan

If Medicare beneficiaries are paying for healthcare services on a percentage basis at the time services are performed or healthcare products are received, what type of Medicare coverage are they using?

- Managed Care Coverage
- Service Rendered Coverage
- Fee-for-Service Coverage

Pretend that you are training a new front office person to register new Medicare patients. You let the new employee register a new patient while you observe. She has the patient complete the applicable medical information, history and insurance forms. Has the Medicare patient been properly registered? What did the new employee forget to do that is necessary during patient registration?

- Gather patient contact and healthcare status information on the applicable forms.
- Copy the Medicare card.
- Call the patient's previous employer to find out about the patient's financial situation.

What information from a patient's Medicare card is necessary in order to ensure that accurate and appropriate information is submitted on a Medicare claim?

- Type of Medicare coverage (Part A, B, or both)
- Patient's address and telephone number
- Patient's full name
- Eligibility start date for Medicare coverage
- Card number

Why is an insurance information form important to the patient registration process?

- The answers help your office determine if the patient has any communicable diseases.
- The answers help your office determine if the patient is covered by any other medical insurance.
- The form usually provides information to the patient about the benefits offered by your organization.

Identify the true statement(s) from the list below.

- Medigap is always the primary insurer when Medicare beneficiaries have authorized Medicare to crossover their claims.
- Medicare is usually the secondary payer when beneficiaries are covered by their own or their spouse's employer group health plan (EGHP).
- Providers cannot submit a claim to Medicare at the same time they bill a potential liability insurer.
- Medicaid is offered to all Medicare beneficiaries under the age of 65.

What other type(s) of insurance could a Medicare beneficiary be covered by that are usually considered the primary insurer?

- Medigap
- Employer Group Health Insurance
- Medicaid
- Liability Insurance

Based on the scenario below, would Medicare be considered primary or secondary insurer?

Scenario: The patient has Medicaid coverage in addition to Medicare.

- Primary insurer
- Secondary insurer

Why is it important to use the written advanced notice in your office?

- It can help prevent your office from having to absorb costs that Medicare will not cover.
- It serves as a warning to your office that you have not provided sufficient information to support a claim or claims that were submitted.
- It informs patients when services may not be covered by Medicare as "medically necessary."

Good try! You scored ___ correct on the Preliminary Knowledge Assessment.

It is advised that you proceed through all course lessons beginning with Lesson One to increase your understanding of Medicare-related front office practices.

The following course lessons provide a detailed explanation of Medicare-related front office tasks, guidelines, and scenarios. Examples and printable job aids are also offered to assist your learning throughout the course.

After completing the lessons, proceed to the Post-Course Knowledge

Assessment to answer questions and receive your final score and course certification.

- Introduction to Medicare
- Medicare Coverage and Eligibility
- Patient Registration
- Medicare as Primary and Secondary Payer
- Other Important Front Office Documents
- Post-Course Knowledge Assessment

Introduction to Medicare

After completing this lesson, you should be able to:

- Identify the basic components of Medicare.

Medicare is a program that was originally formed by the Federal government to provide insurance coverage for persons age 65 or older in order to complement retirement, survivor, and disability insurance benefits provided by Social Security.

Today, the Medicare program also insures the disabled and those afflicted with end stage renal disease (ESRD) as well (as long as certain eligibility requirements are met).

People insured by the Medicare program are called beneficiaries.

Medicare divides its coverage into three parts:

Part A:

Medicare Part A - also known as "Hospital Insurance"

Part A insurance helps pay for inpatient hospital care, inpatient care in Skilled Nursing Facilities (SNF), Home Health care, and Hospice care.

Part B:

Medicare Part B is also known as Supplemental Medical Insurance (SMI).

Part B insurance helps pay for physician services, physician provided outpatient hospital services, physician provided inpatient hospital services, diagnostic tests, clinical laboratory services, outpatient physical therapy, speech therapy services, durable medical equipment, ambulance transportation, and rural health clinic services.

Part C

In 1997, Congress created a set of health care options known as Medicare Part C, or Medicare+Choice.

These plans offer the same benefits as Medicare Part A and B. In addition, many of the plans offer benefits for services not covered by the "traditional Medicare programs," such as hearing aids, dentures and prescription drugs. The scope of additional coverage is based on the individual policy and plan. (For more info, refer to the World of Medicare computer based training course.)

A healthcare person or organization that supplies beneficiaries with healthcare services and products is called a provider.

Introduction to Medicare

Select the correct description of Medicare from the list.

- A privately funded insurance program established by corporations for the elderly and disabled.
- A life insurance program funded by the government for all U.S. citizens.
- A federal health insurance program established by Congress for the elderly, the disabled, and individuals afflicted with end-stage renal disease (ESRD).

Identify the correct description of Medicare Part A from a list.

- A federal medical insurance that helps for inpatient and outpatient care, physician visits, and therapeutic services.
- Hospital insurance that helps pay for inpatient hospital care, inpatient care in a skilled nursing facility, home health care, and hospice care.
- Supplementary medical insurance that helps pay for physician services, outpatient hospital services, diagnostic tests, clinical laboratory services, outpatient physical therapy, speech therapy services, durable medical equipment, ambulance transportation, and rural health clinic services.

Medicare Coverage and Eligibility

After completing this lesson, you should be able to:

- Select the correct eligibility requirements for Medicare Part A and Part B.
- Identify the types of coverage available to a Medicare beneficiary.

In order to qualify for Medicare Part A, beneficiaries must meet certain criteria.

For eligibility of Medicare Part A coverage, an aged person must be:

- ✓ age 65 or older and either,
- ✓ receiving retirement benefits from Social Security or the Railroad Retirement Board; or
- ✓ eligible to receive Social Security or Railroad Retirement benefits.

NOTE: Coverage begins with the month in which the individual attains age 65.

For eligibility of Medicare Part A coverage for a person under age 65, the following requirements must be met:

- They must be eligible to receive Social Security or Railroad Retirement Board disability benefits for 24 months or more; or
- They must be receiving dialysis or renal transplantation for end stage renal disease (ESRD).

For eligibility of Medicare Part B coverage a person must be:

- ✓ eligible based on being either an aged individual, or meet the disability or dialysis requirements;

and

- ✓ selects the use of Medicare Part B benefits; **and**
- ✓ pays the monthly premium for Medicare Part B.

Based on the patient information given below, for what type of Medicare coverage is the patient eligible?

Patient Information: James Nolan, age 68, receiving Social Security benefits for 2 years

- Part A only
- Part B only
- Part A and B

Medicare beneficiaries may receive benefits in two ways:

1. Fee-for-service benefits - Benefits that require patients to pay a deductible (if not previously met) and any applicable co-insurance each time a service is rendered. Patients are also responsible for paying non-covered services (program exclusion), or any items for which they signed a Written Advanced Notice.

2. Managed Care/HMO - A plan where the beneficiaries prepay a set amount (usually a co-payment) for items or services provided by physicians or other health care providers. Most Managed Care programs today are HMOs (Health Maintenance Organizations), although some are also Competitive Medical Plans (CMPs).

What are the two general benefit option plans available to Medicare beneficiaries?

- Fee-for-Service
- Limited Care
- Managed Care
- Service-per-quarter

Patient Registration

After completing this lesson, you should be able to:

- Identify the three basic tasks for receiving a Medicare patient prior to service.
- Select the important criteria needed from the patient's Medicare card from a list or sample card.
- Identify the importance and use of a checklist/questionnaire in determining a patient's Medicare eligibility.

As a front office person, or a person who receives initial patient information there are three major tasks you perform that are vital to the efficiency and financial welfare of the healthcare organization of which you are a part.

- Copying the Medicare card; and
- Obtaining essential patient information; through use of completed medical information/history and insurance forms; and
- Determining Medicare eligibility

Now let's look at each one of these steps individually.

- Copying the Medicare Card
- Obtaining Essential Patient Information
- Determining Medicare Eligibility

Copying the Medicare Card

It is very important that you obtain a copy of a beneficiary's card during a patient's first visit with your facility.

Medicare also recommends that you periodically verify a beneficiary's insurance information to determine if any changes have occurred. If changes have occurred, patient records should be updated accordingly.

The pieces of information that you need to pay close attention to and record from the patient's card are highlighted below and include:

- Exact name
- Claim number
- Type of coverage
- Effective date

The accuracy and verification of the Medicare card information is extremely important because the information will be used on many claim forms and medical documentation materials throughout the patient's history with your facility.

Mistakes in patient information can carry over to Medicare claim forms causing claim rejects, delays in processing, and even denials. These mistakes cause more work and can be quite costly for your organization.

You also need to get additional patient information when registering new patients.

This information is usually obtained by having patients fill out a medical information/history and insurance information form.

Your office or organization may gather patient information via paper forms, or through data entry on a computer.

No matter how you collect patient registration information, it is important that you at least get the following pieces of information:

- Patient's full name (and insured's - if different from patient) directly from patient's Medicare card;
- Patient's address and telephone number;
- Names and identification numbers for insurance coverage (both Medicare plan(s) and others); and
- Date of birth

Obtaining Essential Patient Information

Additionally, you should always get the appropriate patient signatures on Medicare claim forms depending upon the circumstances.

- Block 12 must be signed by the patient if he/she authorizes the release of medical information to Medicare and payment of medical benefits to the provider.
- Block 13 must be signed by the patient if he/she has Medigap and authorizes payment of medical benefits to the provider.

The UB-92 HCFA-1450 and HCFA-1500 (U2) (12-90) claim forms are good references to use for developing an insurance information form for your office or department to use. The information on the insurance information form should at least encompass the information necessary to fill out the Medicare claim form(s) correctly.

Remember, obtaining complete and accurate information from your patent is essential in ensuring the accuracy of Medicare claim information, and patient identity information on medical documentation records.

Also keep in mind:

- The names used on all documentation should match the Medicare card exactly.
- Addresses, phone numbers, and other contact information should be reviewed and updated with the patient periodically to be sure it is correct.
- Any incorrect information on a claim makes the claim subject to rejection or denial.

Select the letter(s) that represent(s) the information on the sample Medicare card that is essential to proper claim processing.

- A - John Doe
- B - 123-45-6789A
- C - HEALTH INSURANCE
- D - (PART A) (PART B)
- E - 7/1/96 7/1/96

Is the information on the sample patient information form correct and ready to be processed?

- Yes
- No

Determining Medicare Coverage

For more information about the Medicare Secondary Payer (MSP) Program, see the MSP computer based training course.

Another important task that can save your office or department time and money is to …

- ✓ Identify all the Medical insurance benefits that each patient has.

Because …
… a patient can be covered by a wide range of insurance plans in addition to Medicare. In cases where a patient has additional coverage, Medicare may be considered the "secondary payer;" and the additional insurance carrier the "primary payer."

Medicare Secondary Payer (MSP) information is discussed in another section of this course.)

For the complete Medicare Secondary Payer (MSP) Program questionnaire, see the MSP computer-based training course.

There are a number of questions you should be asking patients to make sure you have the complete and correct information about their insurance coverage.

1. Is your injury/illness due to:
   - A work related accident or condition?
   - A condition covered under the Federal Black Lung Program?
   - An automobile accident?
   - An accident other than an automobile accident?
   - The fault of another party?
2. Are you eligible for coverage under the Veteran's Administration?
3. Are you employed?
   - Do you have coverage under an Employer Group Health Insurance?
4. Is your spouse employed?
   - Do you have coverage under your spouse's Employer Group Health Insurance?
5. Are you a dependent covered under a parent's or guardian's Employer Group Health Plan?

<u>These questions will help you determine if the beneficiary is</u>:

1. Covered under another policy or government program
2. Potentially eligible for coverage by a different insurer due to an accident or injury that makes a third party liable for medical expenses
3. Eligible for coverage of all expenses over the amount that Medicare covers

Why do you think it is important to identify any insurance coverage beneficiaries may have in addition to Medicare?

- If a beneficiary has other insurance coverage, Medicare may be considered the secondary payer and claims would be processed differently.
- Medicare may be able to bill the beneficiary's insurance company for services they deem to be "medically necessary."

- Your office may be able to submit claims to both Medicare and the beneficiary's other insurance to ensure faster reimbursement.

Medicare as Primary and Secondary Payer

After completing this lesson, you should be able to:

- Identify definitions and true statements regarding the concepts of Medigap, Medicaid, and Crossover.
- Identify the ways a beneficiary could be covered for medical expenses in addition to Medicare coverage.
- Determine whether Medicare is the primary or secondary insurer for a patient.

During patient registration, it is important for front office staff to identify whether a beneficiary's expense should be covered by another insurance before, or in addition to, Medicare. This information helps your provider organization determine whom to bill and how to file claims with Medicare.

This is not an easy task. There are MANY insurance benefits a patient could have, and many combinations of insurance coverage to consider, before determining who pays - and when. Depending on the type of additional insurance coverage a patient has (if any), Medicare may be the primary payer for a patient's claim(s), or considered Medicare Secondary Payer (MSP).

The eligibility questionnaire (discussed in another lesson of this course) will help you determine what types of insurance a patient may have.

However, once a patient's insurance status is determined, you still need to figure out if the condition/injury being currently treated is eligible for coverage by Medicare as the primary payer, or by another insurer as the primary payer.

In two cases where a beneficiary has additional coverage, Medicare is always the primary payer. These two cases are:

- Medigap
- Medicaid

Let's look at each type of additional coverage individually…

Medigap is a privately offered, Medicare-supplemental health insurance policy designed to provide additional coverage that Medicare does not pay. It also helps to satisfy deductible or any coinsurance payment. Medigap does NOT apply to patients enrolled in HMOs.

Example:

Be aware that not all Medicare supplemental insurance is Medigap. Only certain insurance companies are authorized to offer Medigap insurance to Medicare beneficiaries. The Medigap policies offered by these companies are regulated by Medicare law.

Contact your local Medicare contractor for a list of registered Medigap insurers. A list of these contractors can be found at: www.medicare.gov.

When a Medicare beneficiary has elected to purchase a Medigap policy, Medicare must be informed that the beneficiary wishes to have his/her claim information sent to a Medigap insurer. The notification is made by the information you provide on the claim.

The reassignment of the gaps in coverage is called crossover, and eliminates the need for the beneficiary to file a separate claim with their Medigap insurer.

In order to enable to crossover process, beneficiaries must sign an authorization with each of their providers. This authorization is kept in the patient's medical file.

Medicaid is a federally and state funded program through which certain categories of the nation's poor and disabled are entitled to medical and health-related benefits.

The Federal government provides broad guidelines for eligibility, but allows each state to:

- dictate more defined eligibility standards,
- determine the coverage of services,
- set rates of payment, and
- administer the program.

In cases where Medicare beneficiaries are also eligible for Medicaid, the Medicaid coverage is always secondary to Medicare. What Medicaid services cover for those eligible is determined at a state level.

_____ is a situation where gaps in coverage for the medical expenses of a Medicare beneficiary are forwarded to the Medigap insurer for payment.

- Claim Forward
- Medigap Forwarding
- Crossover

Match the terms "Medigap" and "Medicaid" with the correct description for each term. (Note: One match per term)

A federally and state funded program through which certain categories of the nation's poor and disabled are entitled to medical and health-related benefits.

Medigap

A privately offered, Medicare-supplemental health insurance policy designed to provide additional coverage that Medicare does not pay.

Medicaid

An insurance provided to beneficiaries by their employer or the employer of a spouse or other family member.

When a beneficiary has a Medigap policy, or Medicaid coverage, **Medicare is clearly the primary payer**.

However, Medicare is the secondary payer when a Medicare beneficiary has …

- Another insurance policy,
- Benefits under another Federal program, or
- A condition or injury where a third party may be liable for medical expenses,

…it is part of your job as a front office person to help determine whether Medicare is the primary or secondary payer of expenses for a claim. What follows are situations where Medicare is the primary payer and situations where Medicare is usually the secondary payer.

Medicare is the primary payer when beneficiaries are:

- ✓ Covered by Medicare as their soul source of medical and/or hospital insurance.
- ✓ Covered by a Medigap policy or another privately purchased insurance policy (not related to employment status) for amounts above what Medicare pay
- ✓ Covered by Medicaid benefits in addition to Medicare
- ✓ Disabled and unemployed or not covered by a Large Group Health Plan (LGHP)

- ✓ Covered under their own, or a spouse's, Employer Group Health Plan (EGHP)
- ✓ Working disabled with coverage under a Large Group Health Plan (LGHP)
- ✓ Treated or diagnosed with a condition or injury that is due to the fault of another party, and will most likely be covered by a liability insurer
- ✓ Treated for an injury caused by a car accident where no fault auto insurance will cover the medical expenses
- ✓ Afflicted with End Stage Renal Disease (ESRD) and within the 30-month coordination period.

The following chart demonstrates when Medicare is a primary or secondary payer for patients in a variety of coverage situations and Medicare care needs.

Patient situation:	Medicare as Primary Payer:	Medicare as Secondary Payer:
Medicare Eligible with …		
No other insurance	✓	
Medigap supplemental insurance	✓	
Medicaid coverage in addition	✓	
Employer Group Health Plan (EGHP)* coverage		✓
End Stage Renal Disease (ESRD) in 30 month coordination period**		✓
Disability		
Not working/unemployed	✓	
Employed with LGHP*** coverage		✓
Condition/injury due to accident where there is …		✓

No fault (e.g., auto) insurance coverage Liability (e.g., home owners, commercial, malpractice, auto, etc.) insurance coverage Worker's Compensation (see note below)		✓

* An Employer group Health Plan (EGHP) is a health insurance plan sponsored by either a patient's or the spouse of a patient's employer where a single employer of 20 or more employees is the sponsor of 20 or more employees is the sponsor and/or contributor to the EGHP, or two or more employers are sponsors and/or contributors and at least one of them has 20 or more employees.

** The entitlement of Medicare benefits for an ESRD patient begins with a 30-month coordination period. During that period, Medicare is secondary payer to the patient's private insurance or private funds. Medicare remains the secondary payer throughout the entire 30-month coordination period even if the beneficiary becomes eligible for Medicare coverage due to age or disability status.

In addition to the Medicare as primary payer and Medicare secondary payer situations you just learned about, there are other situations where you need to determine Medicare's role as payee.

Some other situations or programs that affect how and when a Medicare claim should be filed are shown below.

Veteran's Administration (VA) Benefits --
Medicare does not cover conditions or injuries that are covered by VA benefits.

Worker's Compensation --
Medicare does not cover conditions or injuries that are covered by Worker's Compensation. If a claim, or a portion of a claim, is denied by Worker's Compensation, a claim may be filed to Medicare for payment consideration on a primary payer basis.

Black Lung Program --
Medicare does not pay secondary to services related to the Black Lung program. However, if a Medicare eligible patient has a condition or injury not related to Black Lung, a claim can be filed to Medicare as the primary payer.

United Mine Workers of America (UMWA) --
Those covered by UMWA are not ever covered by Medicare (as either primary or secondary).

Based on a given scenario, would Medicare be considered the primary or secondary payer?

Scenario: The beneficiary has Medicare Part A and Part B, and has contracted with another insurance company for Medigap insurance.

- Primary payer
- Secondary payer

Scenario: A beneficiary is eligible for Medicare Part A and B coverage, and is also insured through his wife's employer group health insurance.

- Primary payer
- Secondary payer

When Medicare is clearly the secondary payer, there are some steps that should be followed by the provider's organization.

These steps are:

1. File the claim with the primary insurance (employer's group health plan, worker's comp, etc.) first.

2. Attach copies of the payment report, check, etc., once received from the primary insurance company, to the Medicare claim form. Be sure the attached information includes the amounts allowed and paid by the primary insurer.

In **liability cases** where the beneficiary's medical expenses may be covered by a third party's insurance, the provider has a choice of actions. These choices include:

Bill Insurer:

The provider can bill the liability insurer directly. If it is determined that the primary payer will not pay promptly (within 120 days after billing the liability insurer), the provider may file a claim with Medicare for conditional primary payment. If a Medicare conditional payment is made, the provider or supplier may no longer bill the primary insurer or the beneficiary for services that were covered by the Medicare conditional payment. They may only bill the beneficiary for applicable Medicare deductibles and coinsurance.

File a Lien:

When the patient sues the liability insurer for damages, the provider may file a lien against the settlement proceeds of the liability case. If it is determined that the primary payer will not pay promptly (within 120 days after billing the liability insurer), the provider may file a claim with Medicare for conditional primary payment. If a Medicare conditional payment is made, the provider or supplier may no longer bill the primary insurer or the beneficiary for services that were covered by the Medicare conditional payment. They may only bill the beneficiary for applicable Medicare deductibles and coinsurance.

Bill Medicare

If it is determined that payment will not be made promptly (within 120 days), the provider may file a claim with Medicare for conditional primary payment. If a Medicare conditional payment is made, the provider or supplier may no longer bill the primary insurer, nor place a lien against the beneficiary's insurance settlement for Medicare-covered services. They may only bill the beneficiary for applicable Medicare deductibles and coinsurance. Medicare intended these conditional payments as a means to avoid imposing a financial hardship on the patient.

Match each of the three major steps of filing a Medicare Secondary Payer (MSP) claim with the correct description of that step.

Step 1	Complete the Medicare claim form.
Step 2	Attached copies of the payment report, check, etc. from the primary insurance company to the claim form.
Step 3	File a claim with the primary insurance company.

Identify the true statement(s) from the list below:

- In liability cases where the beneficiary's medical expenses may be covered by a third party's insurance, the provider can file a claim with Medicare first. Then file an adjusted bill with the liability insurer.

- In cases where the beneficiary's medical expenses may be covered by a third party's insurance, the provider can file a claim with Medicare and the liability insurer at the same time and file an amendment with the organization that pays first.

- In liability cases where the beneficiary's medical expenses may be covered by a third party's insurance, the provider can bill the liability insurer directly. The provider must then wait 120 days before filing a claim with Medicare.

Other Important Front Office Documents

After completing this lesson, you should be able to:

- Identify the importance and use of a written advanced notice and Medicare Development Letter.

There are two other documents specific to the Medicare program that you may be responsible for processing as a front office person.

These documents are:

- Written advanced notice
- Medicare development letter

The written advanced notice is proof that your office has given patients notice that the services about to be provided may not be covered under Medicare because they are not medically reasonable or necessary, and that he/she is responsible for the charges.

The Development Letter is notice from Medicare that a claim submitted by your provider organization cannot be processed without additional information and/or documentation.

Written Advanced Notice:

There are some guidelines as to what constitutes an acceptable written advanced notice.

These guidelines are:

- Notice must be given in writing, prior to providing the patient with an item or service.

- Notice must include:

  - The patient's name
  - Date(s)
  - Description of item or service
  - Reason(s) why the item or service may not be considered medically necessary

- The notice must be signed and dated by the patient each time an item is given or service is rendered that may not be deemed "medically necessary."

Medicare Part B only allows coverage for services and items which are "medically reasonable and necessary" for treatment/diagnosis of a patient.

Medical necessity may be determined according to several factors. A few of these factors include general rules such as:

Rules of thumb for determining if a service or item is "medically necessary"

- ✓ Items or services provided to the patient must be appropriate for that patient's treatment/diagnosis.

- ✓ Documentation (when identified as required, or when requested) supports the medical need.

- ✓ The frequency of service or dispensing of an item is within the accepted standards of medical practice.

Development Letter

A Medicare Development Letter is sent to a provider when a claim is filed that needs additional information or documentation.

These letters usually detail what information is necessary in order for Medicare to resume processing on a specific claim or claims.

As a front office person, you may be responsible for gathering and sending the information that Medicare requests.

- ✓ Also note that there is usually a time limit placed on return of the requested information. If the additional information is not sent to Medicare within the time frame communicated in the development letter, the services at issue will be denied payment by Medicare.

Identify the true statement(s) from the list below.

- The written advanced notice is a notice from Medicare that a claim submitted by your provider organization cannot be processed without additional information and/or documentation.

- A Medicare Development Letter is sent to a provider when a claim is filed that needs additional information or documentation. There is no time limit on responding, but a claim may be denied if the wrong information is sent.

- The written advanced notice must include the patient's name, date(s), a description of the item or service provided, and the reason(s) why the item or service may not be considered "medically necessary."

Post-Course Knowledge Assessment

Now it is time to take the Post-Course Knowledge Assessment to determine how much you have learned from this course about front office tasks related to Medicare claim processing.

This Assessment will ask you to answer questions related to the content of this course. Please note that you will not be able to exit the Assessment once you enter it.

Assessment feedback is given after you have answered all questions, and indicates which questions you answered correctly. Correct answers to the questions will also be provided in the Assessment feedback.

Finally, you will have the option to print your "Progress Report" which contains your Preliminary and Post-Course Knowledge Assessment scores.

You may re-take the Post-course Knowledge Assessment as often as you like.

_____ is a federally funded health insurance program for the elderly, disabled, and those afflicted with end-stage renal disease. Those who receive Medicare coverage are called _____. Those physicians and healthcare organizations who participate in the Medicare program are called _____.

Select the option below that correctly fills in the blanks above.

- Medicaid, Providers, Patients
- Medicare, Beneficiaries, Unassigned
- Medicare, Beneficiaries, Providers
- Medicaid, Payees, Providers

In which of the situations below would an individual be eligible for Medicare Part A?

- You are over 65 and receiving Social Security.
- You are under 65 and have children under the age of 10.
- You are under 65 and a kidney transplant patient.

- You are under 65 and have been receiving Railroad Retirement Board benefits for a year.

What type of Medicare benefits does an individual have if he/she is covered under a Health Maintenance Organization (HMO)?

- Managed Care Coverage
- Service Rendered Coverage
- Fee-For-Service Coverage

What information from the Medicare card is necessary in order to ensure accurate and appropriate Medicare claims?

- Type of Medicare coverage (Part A, B, or both)
- Patient's address and telephone number
- Patient's full name
- Eligibility start date for Medicare coverage
- Card number

Select the items from the sample card that you need to record for use on medical documentation and Medicare claim forms.

- Patient's full name
- Card number
- Type of Card
- Eligibility start date for Medicare coverage
- Type of Medicare coverage (Part A, B, or …)

Why is an eligibility questionnaire important for patients to fill out?

- The answers help your office determine if the patient has any communicable diseases.
- The form usually provides information to the patient about the benefits offered by your organization.
- The answers help your office determine if the patient is covered by any other medical insurance.

Match the term on the left with its correct description on the right:

Crossover	When the medical expenses of a Medicare beneficiary not covered by Medicare are forwarded to a Medigap insurer contracted with by the beneficiary for payment of those non-covered Medicare services.
MSP	A privately offered, Medicare-supplemental health insurance policy designed to provide additional coverage that Medicare does not pay.
Medicaid	Identifies Medicare as the secondary payer for some or all claims submitted for a beneficiary. Medicare is identified as a secondary payer when a beneficiary has insurance coverage additional to Medicare that is considered primary.
Medigap	A federal/state program that provides health insurance for categories of the poor and medically indigent.

What type of additional insurance coverage does a Medicare beneficiary have if the other insurance is primary to Medicare coverage and is provided as a benefit through his/her spouse's job?

- Medigap Coverage
- Employer Group Health Insurance
- Blank Lung Program

Based on the scenario below, would Medicare be the primary or secondary insurer?

Scenario: The patient injured himself falling down a flight of icy stairs at a friend's home. The friend owns the home and has homeowner's insurance.

- Primary insurer
- Secondary insurer

What piece of documentation is used to notify your patients that services and/or products about to be provided may not be covered by Medicare?

- Advanced Development Form
- Development Letter
- Written Advanced Notice

You scored ____ correct on the Post-Course Knowledge Assessment.

Refer to the button bar below to see which questions you answered correctly or incorrectly. Click numbered button to view the correct response for each question. A green button indicates a correct answer. A red button indicates an incorrect answer.

Your course "Progress Report" containing both the Preliminary and Post-Course Knowledge Assessment scores can be obtained by clicking the Print Button below. Front Office course certification is given to individuals scoring 90% or better on the Post-Course Knowledge Assessment.

- You may retake the Post-Course Knowledge Assessment at any time.

(End of Front Office Section)
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